MEDI-CAL UPDATE

Medical Services
Bulletin 334

Billing and Policy
General Medicine Bulletin 334 **May 2002**

Billing and Policy Contents

Articles with related Part 1 Manual Replacement Pages may be found in "Program and Eligibility." Articles with related Part 2 Manual Replacement Pages may be found in "Billing and Policy."

Your Medi-Cal Update *may not always contain a "Billing and Policy" section.*

Artery Harvesting: New Surgery Benefit

Effective for dates of service on or after March 7, 2002, CPT-4 code 35600 (harvest of upper extremity artery, one segment, for coronary artery bypass procedure) is a covered benefit. This procedure is exempt from the use of modifier -51 (multiple procedures). *This information is reflected on manual replacement page tar and non cd3 5 (Part 2).*

Gemcitabine: Expanded Benefit

Effective June 1, 2002, gemcitabine 200 mg (HCPCS code X7630) is reimbursable for gallbladder cancer treatment. Code X7630 is reimbursable when used in an outpatient setting, alone or in combination with other drugs when billed with ICD-9-CM codes 156.0 – 156.9 (malignant neoplasm of gallbladder and extrahepatic bile ducts). *These changes and additional information for billing code X7630 are reflected on manual replacement page chemo 10 (Part 2).*

HIV Drug Resistance Testing: 'By Report' Items Changed

Effective June 1, 2002, the list of "By Report" items required for billing Human Immunodeficiency Virus (HIV) drug resistance testing by genotype and phenotype (CPT-4 codes 87901 and 87903) has changed, and the number of items required for medical justification is reduced. The "By Report" items soon to be required include recipient age, gender and location of residence; reason for ordering an HIV drug resistance test; current antiretroviral medications and duration of use; and current viral load test results. *Refer to the updated billing requirements on manual replacement page path micro 4 (Part 2).*

Anesthesia Time Units: Policy Clarification

Providers are reminded that current policy is to reimburse for medically necessary anesthesia services (CPT-4 codes 00100 – 01999) based on 15-minute increments of anesthesia time. Anesthesia start and stop times (in military time format) and the total anesthesia time must be documented in the *Reserved For Local Use* field (Box 19) of the claim. Claims will be denied if the start and stop times are not indicated. If the start and stop time is less than the total quantity billed in the *Days or Units* box, the claim will be reimbursed according to the start and stop time.

*Please see **Anesthesia**, page 2*

Anesthesia *(continued)*

When billing for regional obstetrical anesthesia (for example, epidural or caudal), in addition to the documentation requirements noted above, providers must also document the time actually spent with the patient in the *Reserved For Local Use* field (Box 19) of the claim. Only actual time spent with the patient may be billed. Claims will be denied if the actual time spent with the patient is not documented. If the actual time spent with the patient is less than the total quantity billed (in the *Days or Units* box), the claim will be reimbursed according to the actual time spent with the patient.

Note: Claims billing for more than 40 units of time (10 hours) require that an anesthesia report be attached to the claim.

This policy has been clarified on manual replacement pages anest 1 and 2 (Part 2) and anest hcfa 2 (Part 2).

Radiology and Pathology/Laboratory Billing: CLIA Proficiency Testing Certification Reminder

The Centers for Medicare & Medicaid Services (CMS) (formerly HCFA) requires Clinical Laboratory Improvement Amendments (CLIA) proficiency testing for Medi-Cal reimbursement of selected CPT-4 codes in the 70000 (radiology) and 80000 (laboratory) range. Questions regarding state and federal requirements for proficiency testing should be directed to the Department of Health Services, Laboratory Field Services, at (510) 873-6327. For more information about proficiency testing, refer to the *Pathology: An Overview of Enrollment and Proficiency Testing Requirements* section in the appropriate Part 2 manual.

Incontinence Supplies: Billing Limit Reminder

Providers are reminded that, pursuant to *Welfare and Institutions Code*, Section 14125.4, the billing of incontinence supplies without prior authorization is limited to $165, including sales tax and markup, per recipient, per calendar month. Incontinence creams and washes are not subject to this billing limit. The affected supplies include disposable briefs, diapers, underpads, undergarments, pant and pad systems and liners or pads. *A Treatment Authorization Request* (TAR) is required for charges exceeding the cumulative dollar limit for the month. Claims exceeding this limit without a TAR will be denied.

Ventilator Management: Clarification

Physicians may be reimbursed for ventilation management services (CPT-4 codes 94656 and 94657) if provided in an inpatient setting. For the purpose of Medi-Cal, ventilator management is not just writing orders, but includes actually adjusting the ventilator settings for the 24 hours being billed. *This policy is reflected on provider manual page respir 8 (Part 2).*

California Children's Services: Address, Telephone Changes

The address and telephone numbers for the California Children's Services (CCS) Headquarters Office and Sacramento CCS Regional Office have been updated, as has the address for the Southern California CCS Regional Office.

California Children's Services
Headquarters Office
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 327-1400

Southern California
CCS Regional Office
311 South Spring Street, Suite 01-11
Los Angeles, CA 90013-1211
(213) 897-3574

Sacramento CCS Regional Office
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 327-1400

Refer to updated manual page cal child 1 (Part 2).

Medi-Cal List of Contract Drugs: Updates

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications.*

Addition, effective February 1, 2002

Drug	Size and/or Strength
* EFAVIRENZ	
Tablets	**600 mg**
* Restricted to use in the treatment of AIDS or AIDS-related conditions.	

Additions, effective May 1, 2002

FORMOTEROL FUMERATE		
Capsules for oral inhalation	**12**	**mcg**
MEDROXYPROGESTERONE ACETATE		
Injection	**150**	**mg/cc**
	400	**mg/cc**
Injection, prefilled syringe	**150**	**mg/cc**

Family PACT
Planning • Access • Care • Treatment

Level V Surgical Pathology: New Benefit

Effective June 1, 2002, CPT-4 code 88307 (Level V – Surgical pathology, gross and microscopic examination) is reimbursable when billed with a LEEP procedure, CPT-4 code 57460 (colposcopy [vaginoscopy]; with loop electrode excision procedure of the cervix). In order to be reimbursed, providers must bill code 88307 with ICD-9-CM diagnosis code 622.1 (dysplasia of cervix [uteri]) and one of the following primary diagnosis codes: S101 – 102, S201 – 202, S301 – 302, S401 – 402, S501 – 502, S701 – 702 or S901 – 902. This service applies to female recipients only.

Replacement pages for the Family PACT *Policies, Procedures and Billing Instructions* (PPBI) manual will be issued in a future mailing to Family PACT providers. For more information regarding Family PACT, call the Health Access Programs (HAP) Hotline at 1-800-257-6900 from 8 a.m. to 5 p.m., Monday through Friday, except holidays.

Instructions for Manual Replacement Pages

General Medicine (GM) Bulletin 334 May 2002

Part 2

Remove and replace:

anest 1/2
anest hcfa 1/2
cal child 1/2
chemo 9/10
medi ms 1/2 *****
path micro 3/4
respir 7/8
tar and non cd3 5/6

* Pages updated/corrected due to ongoing provider manual revisions.